Instructions
Professional Visit Progress Note
MIHP 011 (11/01/15)

These instructions are intended to clarify data fields that users have asked about in the past and to provide definitions for other fields to ensure that all users are interpreting them in the same way. If you have any questions about these instructions or think further instructions are needed, please contact Deb Marciniak at marciniakd1@michigan.gov or 517 324-8314.

One *Professional Visit Progress Note* must be completed for each professional visit conducted. The progress note consists of three pages. You must always complete pages one and two. Use page three only if you address more than two *POC 2* risk domains at one professional visit.

WHEN NOT TO USE THIS PROGRESS NOTE

There are three *Substance-Exposed Infant (SEI) Plans of Care 2* (positive at birth, primary caregiver use, and environmental exposure). When you use any of them, you must also use the *Professional Visit Progress Note – Substance Exposed Code 96154*. There is a separate set of instructions for completing the SEI progress note. You must use the *SEI Plans of Care* and progress note after the 18th infant visit, but you may choose to use them at any point during the course of care for the infant.

PAGE ONE - Top Section

- Blended Visit: Check this box if you are serving two or more beneficiaries with open cases (*Risk Identifier* completed; *Discharge Summary* not completed) at this visit. This visit must be billed consistently under the Medicaid ID number of only one of the beneficiaries. You may not switch back and forth from one beneficiary ID number to another.

- Trimester: Indicate the beneficiary's trimester of pregnancy at the time of this visit. Per ICD-10 and the American College of Obstetricians and Gynecologists, trimesters are defined as follows:

  First trimester: Less than 14 weeks, 0 days
  Second trimester: 14 weeks, 0 days to less than 28 weeks, 0 days
  Third trimester: 28 weeks, 0 days until delivery

  Check the "unspecified" box if the trimester in unknown. Check the "NA" box if the beneficiary is not pregnant (e.g., mother has had the baby and this is a postpartum visit, this is an infant visit, mother has lost the baby but you are still completing maternal visits, etc.). You will need trimester information for billing purposes under ICD-10.

- Beneficiary: Write the beneficiary's first and last name.

- Medicaid Number: Write the beneficiary's Medicaid ID number. If you do not yet have the ID number, leave this field blank. When you obtain the ID number, return to the *Professional Visit Progress Note* and enter it.

- Type of visit: Check the box to indicate whether this is a maternal visit or an infant visit. If it was a blended visit, check the "maternal" box if visit is being billed to mother's Medicaid ID number and check the "infant" box if visit is being billed to the infant's Medicaid ID number.

- Medicaid Health Plan (MHP): Write the name of the beneficiary's MHP. If beneficiary is not yet enrolled in an MHP, write "FFS" or "straight" or "not in health plan"; do not insert "0". Remember to check CHAMPS before each visit to see if beneficiary has enrolled in a MHP since your last visit.

- Location of Visit: Check the appropriate box for the location of the visit**.** If the location is not in the office or the home, check the "other" box and write the location of the visit on the line provided. If "other," write the reason why the visit was not held in the office or home.

- Date of Visit: Write the complete date of the visit (month, day, and year). You are not required to use the mm/dd/yyyy format here.

- Time In and Time Out: Write the time the visit began and the time it ended. Each visit must last for a minimum of 30 minutes in order to be billable.

- Education Packet Reviewed this Visit/Text4baby Messages Discussed:
  If content from the *MIHP Maternal and Infant Education Packet,* such as breastfeeding, was reviewed this visit, check the appropriate box. If Text4baby messages were reviewed this visit, check the appropriate box. If neither education packet content nor Text4baby messages were discussed, check the "neither" box.

  On the next line, list the education packet topic(s) discussed/text4baby message(s) reviewed with the beneficiary this visit. **Do not use this field to document use of any other educational materials with the beneficiary**. For example, if you discussed a topic covered in the education packet (e.g., perinatal depression) but you used a different publication (e.g., the HRSA depression booklet), document it under "other visit information." Avoid abbreviations when documenting the topic discussed, as they may not be recognized by other staff or by your reviewer.

If the educational packet or text4baby was used in conjunction with a *POC 2* domain intervention, provide additional documentation as prompted in the "Domain/Risk Addressed" section. If they were not used in conjunction with a *POC 2* domain intervention, no further documentation is required, but you may choose to comment further under "other visit information."

- First Time Mother? Check the yes box if the beneficiary is a first time mother and the no box if she is not. A first time mother is one who has had a live birth. This does not include miscarriage, abortion or stillbirth. All first time mothers should be referred to childbirth education classes.

- Order in Place for RD Services? If the visit is conducted by a dietitian, a valid standing order or an individual order from the beneficiary's medical care provider must be in the chart and the "Yes" box must be checked. If the visit is not conducted by a dietitian, the "NA" box must be checked, along with the box identifying the discipline of the professional conducting the visit.

Middle and Bottom Sections of Page 1 (used to document *POC 2* interventions provided at this visit)

NOTE: These two sections are exactly the same. The only difference is that they are numbered sequentially. They are used to document different domains if more than one domain is addressed at the same visit.

- 1st Domain/Risk Addressed (*check one*): Check the appropriate box for the 1st maternal OR infant domain/risk addressed at this visit. Do not document both infant and maternal domains on the same progress note. Check only one domain box in each section. If the beneficiary is the infant, the mother's risk domain interventions must be documented as Maternal Considerations. In this case, check the "Maternal Considerations" box and identify the maternal risk domain that was addressed in the space provided.

- Level of Intervention: Check the appropriate box for the level of intervention provided. The options are low, moderate, high, and emergency. However, not every *POC 2* domain includes interventions at all four levels. The intervention level documented here absolutely must correspond to the risk level documented on the *POC 2* for this domain.

- Interventions Provided**:** The interventions on each *POC 2* risk domain are numbered. Write the number of each specific intervention implemented at this visit on the line provided. Use this section only to document interventions that come from the *POC 2*. Document other educational or care coordination activities under "Other visit information" on page 2 of the progress note.

- Narrative about Mother/Care Giver's Reaction to Intervention Provided: In the space provided, write a brief description of the Mother/Primary Caregiver's reaction to the numbered interventions specified in the previous field. For sample brief descriptions, see *Documenting Reactions to Interventions* under "Policy and Operations" on the MIHP web site. If you run out of room, you can continue your narrative on page 2 of the progress note under "other visit information," but be sure to clearly indicate that this is what you have done. There are additional spaces on page 2 of the progress note form to document visit information that does not directly pertain to the *POC 2* domain interventions implemented at this visit, including outcome of referrals made at a previous visit.

PAGE TWO

- Beneficiary: Write the beneficiary's first and last name.

- Medicaid Number: Write the beneficiary's Medicaid ID number. If you do not yet have the ID number, leave this field blank. When you obtain the ID number, return to the *Professional Visit Progress Note* and enter it.

- Other visit information: Write a brief description of the portion of the visit that was not focused on implementing the *POC 2* domain interventions. This is where to document:
  - Care coordination provided for any beneficiary whose Medicaid insurance was not billed for this visit (blended visit).
  - Education provided on a *POC 1* topic that is not a *POC 2* risk domain for this beneficiary.
  - *ASQ-3* or *ASQ: SE-2* was administered.
  - Anything else that you want your team members to know.

  This is not a required field on every progress note. Use this field as needed.

- Outcome of previous referrals: Write a brief description of the outcome of referrals made at previous visits. For example, "beneficiary followed through with call to CMH and has an appt. on such and such a date," "beneficiary decided not to access this resource," "beneficiary obtained food from the food bank," etc. If your agency uses the optional *MIHP Referral Follow Up Form*, insert the date you asked the beneficiary about the outcome of the referral in the "Date of follow up" column on that form, but you must still complete the "Outcome of previous referrals" on the *Professional Visit Progress Note*. This documentation must be provided within 3 professional visits from the date of the referral. This is not a required field on every progress note, as it depends on if and when referrals were made at previous visits and if the outcomes of the referrals were already documented.

The next section on page two consists of a block of questions to which you MUST respond on EVERY progress note. All have "yes" and "no" options, most have "NA" options, and one has an "unknown" option.

- Medical care provider appointments kept since last visit**:** Check "yes," "no" or "unknown" regarding whether the beneficiary attended scheduled medical care provider appointments since the last time she was visited by MIHP staff. If an appointment was not scheduled, check "NA."

- Family planning discussed this visit: Check "yes" or "no" regarding whether family planning was discussed this visit with the beneficiary or the beneficiary's primary caregiver if the beneficiary is an infant. Family planning options must be discussed throughout the course of care (at least once).

- WIC services being received: Check "yes" or "no" regarding whether the beneficiary is currently receiving WIC services. WIC enrollment must be determined at every visit.

- Infant immunization discussed this visit: Check "yes" or "no" to indicate whether or not infant immunizations were discussed. Infant immunization status must be discussed throughout the course of care (at least once).

- Mother immunization discussed this visit: Check "yes" or "no" to indicate whether or not the immunization status of the mother was discussed. The mother's immunization status must be discussed throughout the course of care (at least once).

- Safe Sleep addressed this visit: Check "yes" or "no" to indicate whether or not safe sleep was discussed.

- Breast feeding education provided this visit: Check "yes" or "no" to indicate whether or not breast feeding education was provided during this visit. Check "NA" if there is documentation that the mother does not intend to breastfeed and does not wish to discuss it further.

- Encouraged to attend group child birth education this visit: Check "yes" or "no" to indicate whether or not the pregnant woman was encouraged to attend group child birth education this visit. Check "NA" if the beneficiary is an infant. This box must be checked at least once for all first-time mothers.

- Encouraged to attend group parenting education this visit: Check "yes" or "no" to indicate whether or not the beneficiary was encouraged to attend group parenting education this visit. Check "NA" if the beneficiary is a pregnant woman, since she is not eligible for group parenting classes until the infant is born or if she has already attended parenting classes.

- Plan for Next Visit: Write a brief description of the plan for the next MIHP visit. When completing this field, it's good care coordination practice to be as specific as possible. This helps you, the other members of your team, and the beneficiary (who should know what to expect) to be clear about next steps and to prepare to

implement them. For sample descriptions of plan for next visit, *see "Plan for Next Visit" on MIHP Professional Visit Progress Note* on the MIHP web site.

- New referrals: Check all boxes that apply for referrals made this visit. If you check the "Other" box, use the space provided to specify where you referred the beneficiary. An alternative is to use the optional *MIHP Referral Follow Up* form. If new referrals are documented on the *Referral Follow Up* form instead of on the progress note, check the "See Referral Follow up Form" box at the top of the new referrals section. This is not a required section on every progress note. This section is completed only if one or more referrals are made at this visit.

- Signature and credentials: Legibly sign your first and last name, followed by your professional credentials with licensure.

- Signature Date: The date required here is the date that the progress note was completed and signed. This date may be different from the "Date of Visit" documented on page one of the progress note.

PAGE THREE

Page 3 is required only if you address more than two risk domains this visit.

- Beneficiary: Write the beneficiary's first and last name.

- Medicaid Number: Write the beneficiary's Medicaid ID number. If you do not yet have the ID number, leave this field blank. When you obtain the ID number, return to the *Professional Visit Progress Note* and enter it.

- 3rd and 4th Domain/Risk Addressed Sections: Use this page if you addressed more than two domains at this visit. The instructions for completing these sections are exactly the same as those on page 1 (middle and bottom sections) of these instructions.

Why Cert Tool Indicator #2 - Professional Visits Progress Notes Gets Dinged at Certification Review

#2. SUFFICIENTLY DETAILED CLINICAL RECORD

a. At least 80% of *Professional Visit Progress Notes (MIHP 011)* reviewed are complete and accurate with respect to each required data field.

Progress Notes are not complete. Required data fields are left blank.

Top of page 1:

- Medicaid number is left blank.
- Medicaid Health Plan is left blank.
- The "Topic Reviewed" is left blank when the educational packet or text4baby box is checked. (Or the "Topic Reviewed" is not a topic covered in the educational packet or text4baby.)
- Type of visit (maternal or infant) is left blank.
- Location of visit is left blank.
- Order in place for RD services and NA are both left blank.
- First-time mother box is left blank.

Domain/Risk Addressed Section:

- Level of intervention is left blank.
- "Interventions Provided" is left blank.
- In an infant chart, maternal risk domains are not charted under" Maternal Considerations."
- "Narrative about Mother/Care Giver's Reaction to Intervention" is left blank.

Center section of page 2:

- Boxes are left blank.

Bottom of page 2:

- Professional credentials are missing.

b. At least 80% of *Professional Visit Progress Notes (MIHP 011)* reviewed reflect the *POC Part 1* and/or the *POC Part 2*.

Domain risk level does not match the risk level on the *POC 2*.